Health History Questionnaire

La Jolla Village Family Medical Group 858-450-5900
8950 Villa La Jolla Dr. Suite C129,La Jolla CA 92037

DATE_____ Home_____Work_____
Mobile_____
Email_____
Race_____ Ethnicity_____ Single___ Divorced____
NAME _____ DOB _____ Age ____ Married____ Widower_____
Address _____
Occupation _____ All previous occupations _____
Birthplace_____ All states/countries lived in_____

Date of last physical examination? _____

Please list all current symptoms.

1._____
2._____
3._____
4._____

Physician's Notes

5._____

Routine check-up-no problems_____

Note: ***This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so.***

Family History:	If Living		If Deceased Age at Death	Cause	Has any blood Relative ever Had:	Please Circle No or Yes		Who
	Age	Health						
Father					Allergies	No	Yes	
Mother					Asthma	No	Yes	
Brother or Sister					Arthritis	No	Yes	
1.					Glaucoma	No	Yes	
2.					Cancer	No	Yes	
3.					Tuberculosis	No	Yes	
4.					Diabetes	No	Yes	
5.					Heart Trouble	No	Yes	
6.					High Blood Pressure	No	Yes	
Husband or Wife					Stroke	No	Yes	
Son or Daughter					Epilepsy	No	Yes	
1.					Substance Abuse	No	Yes	
2.					Depression	No	Yes	
3.					Emotional Problems	No	Yes	
4.					Suicide	No	Yes	
5.					Kidney Trouble	No	Yes	
6.					Thyroid Disease	No	Yes	

Personal History: Circle any of the items listed below that apply to you:

Measles (2 week)
German Measles (3 day)
Mumps
Chicken Pox
Whooping Cough
Scarlet Fever/Scarlantina
Diphtheria
Pneumonia
Influenza
Pleurisy
Rheumatic fever or any heart problem
Arthritis/Rheumatism
Any bone or joint disease
Neuritis or neuralgia
Bursitis, Sciatica, or Lumbago

Polio or Meningitis
Bladder or kidney infection
Gonorrhea, Syphilis, or Genital Herpes
Anemia
Yellow Jaundice or Hepatitis
Epilepsy
Migraine headaches
Tuberculosis
Mononucleosis
Diabetes
Cancer
High blood pressure
Low blood pressure
Nervous breakdown
Food, chemical or drug poisoning
Hay fever

Asthma
Hives
Eczema
Frequent infection of boils
Any other disease
ALLERGIES: Are you allergic to:
Penicillin or sulfa
Aspirin, codeine, or morphine
Mycins or other antibiotics
Merthiolate or Mercurochrome
Any other drugs
Any foods
Adhesive tape
Nail Polish or other cosmetics
INJURIES: Have you had any:
Broken or cracked bones

Recent Sprains
Severe lacerations
Dislocations
Concussion or head injury
Ever been knocked unconscious
Blood or Plasma transfusions
WEIGHT: Now_____ 1 year ago_____
Desired_____
HABITS:

Use of seatbelts_____
Alcoholic beverages:
Never, 1-2 drinks/wk 3-6 drinks/wk
7-24 drinks/wk., Over 24 drinks/wk
Have been treated for alcoholism
Use: Cigarettes(____) packs per day
Cigars, Pipe, Chewing Tobacco, Snuff
How long?_____
Do not smoke now but have in past

Diet_____
EXERCISE:
Type_____
_____
Frequency, distance or amount_____
_____
(PLEASE TURN OVER)

HOSPITALIZATIONS: List all hospitalizations (for illness or surgery), beginning with the most recent.

Date	Reason	Hospital	M.D.

Circle any of the items below that apply to you…other than those mentioned in the above hospitalizations.

SYSTEM REVIEW:

Any eye disease, injury, impaired sight
Any ear disease, injury impaired hearing
Any trouble with nose, sinuses, mouth, throat
Problems with your teeth
Fainting spells
Convulsions or seizures
Paralysis or numbness
Dizziness
Frequent or severe headaches
Difficulty remembering or concentrating
Difficulty sleeping
Frequent crying spells
Difficulty related to work or family problems
Thoughts about committing suicide
Enlarged glands
Enlarged thyroid or goiter
Skin problems
Lumps in your breasts
Chronic or frequent cough
Chest pain or angina pectoris
Spiting up of blood
Night sweats
Shortness of breath
Palpitation or fluttering heart
Heart murmur
Swelling of hand, feet or ankles
Extreme tiredness or weakness
Varicose veins
Kidney disease or stones
Bladder disease
Albumin, sugar, pus, blood in urine
Difficulty urinating
Get up at night to urinate
Abnormal thirst
Stomach trouble or ulcer
Indigestion or heartburn
Liver or gallbladder disease
Colitis or other bowel disease
Hemorrhoids or rectal bleeding
Constipation or diarrhea
Recent change in appetite or eating habits
Recent change in bowel habits or stools
Black bowel movements
Stiff, painful or swollen joints
Sexual difficulties
Sex is not entirely satisfactory

Have you had a sigmoidoscopy: Yes No Date_____

X-RAYS: Have you had X-rays of:
Chest Stomach (Upper GI) DexaScan Date _____
Back Colon (Barium enema)
Extremities Gallbladder
Other _____

EKG: Have you had an electrocardiogram: Yes No

IMMUNIZATIONS: Have you had these immunizations:
Measles and Mumps
Smallpox
Tetanus (date of last shot)_____
Polio within last 10 years
Diphtheria within last 10 years
Influenza within last year: Date_____
Pneumovax (Pneumonia) Date_____

DRUGS: Do you use:
Marijuana: Never Occasionally Regularly
Other drugs: e.g., LSD, other_____
Never Occasionally Regularly

DES Exposure: Yes No
Exposure to insecticides Yes No Type_____

Circle those used below:

Laxatives	Aspirin
Vitamins	Cortisone
Tranquilizers	Appetite depressants
Sleeping pills	Antacids

Have you been treated for drug abuse: Yes No
Have taken insulin or tablets for diabetes: Yes No
Have taken hormone shots or tablets: Yes No

Present medications: List all prescription drugs that you are presently taking:

Medication	**Dose**	**Frequency**

MEN ONLY
Have you ever had swelling of or lumps on testicles? Yes No
Current method of birth control_____

WOMEN ONLY
Menstrual History: Age of onset _____
Date of last period: _____/_____/_____
Cycle (from start to start) _____days
Usual duration of flow is _____days
Flow is: heavy medium light
Pain or cramps
Periods are irregular

Have had vaginal infections or frequent discharge Yes No
Have taken birth control pills or used an IUD Yes No
Have had abnormal PAP Yes No
Current method of birth control_____
Pregnancies: Total number _____
How many children were born alive? _____
How many stillbirths? _____
How many premature? _____
How many Cesarean sections? _____
How many miscarriages? _____
How many abortions? _____
Date of last mammogram _____/_____/_____

_____ _____
Physician's Signature Date Reviewed